MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 6236 234

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Pr. Geo.
City or town: Cave Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. Geo.
City or town: Cave Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6271 Brandon Park Dr.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Wm A. Wilson Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Pink Bernice
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Nov 24 1897

8. AGE: Years	Months	Days	If less than one day
54	7	14	....hrs. ....min.

9. Birthplace: Sag Harbor N.Y.
(Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business: U. S. Govt.
MOTHER 12. Name: Thos H Wilson
FATHER 13. Birthplace: Wales Maryland
MOTHER 14. Maiden name: Bernice PRESTON
15. Birthplace: Sag Harbor
16. Informant: Helen Cingle
Address: 2104 Suitland Terrace SE

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 19-1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Maryland
18. Funeral director: Thomas F. Murray
Address: 2007 - Nichols ave S.E.
19. June 18 1945 Howard J Beach
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 19 45 at 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3rd 19 45 to June 16 19 45
and that I last saw him alive on June 15 19 45
Immediate cause of death: Tuberculosis of Rt Lung.

DURATION
3 Mo.

Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chester Lyle M D
M. D. or other
Address: 806 D St S.E. Date signed 6/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-P)

CERTIFICATE OF DEATH

★ 06237

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: RURAL- Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 11 mo., 2 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 11 mo., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 56- Myrtle St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: LUCIUS ANDERSON

3.(b) Social Security Number: 579-12-0896

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 25, 1907

8. AGE: Years	Months	Days	If less than one day
38	4	24	hrs. min.

9. Birthplace: Bernvillen, So. Carolina
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: -

FATHER
12. Name: Claude Anderson
13. Birthplace: Bernvillen, S. Carolina

MOTHER
14. Maiden name: Irene Greet
15. Birthplace: Bernvillen, S. Carolina

16. Informant: decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: June 19, 1945 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: John J. Stewart Jr.

Address: 30 H Street N.E.

19. June 19 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1945 at 11.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1943 to June 19 1945 and that I last saw him alive on June 19, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yr 1 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 6/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

06238

Reg. Dist. No. 231

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince George

City or town Chevelly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 days

Hospital, institution, or street address where death occurred: Dr George Gen'l Hospital

How long in hospital or institution? 2 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County ..... (1)

City or town Landover

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Earl T Baldwin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Mrs Lucy A Baldwin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 1 1897

8. AGE: Years	Months	Days	If less than one day
47	9	15	..... hrs. ..... min.

9. Birthplace Washing D.C. (Town, county, and state)

10. Usual occupation Auditor

11. Industry or business General Accounting Office

FATHER 12. Name Henry T Baldwin

13. Birthplace Washing D.C.

MOTHER 14. Maiden name Gertrude Harlowe

15. Birthplace Washington D.C.

16. Informant wife Lucy A Baldwin

Address London Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 18. 1945 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Colmar Manor Md

18. Funeral director F Fascia sons

Address Hyattsville Md

19. 6/19 1945 Amanda Downey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945 at 11 26/60 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1945 to June 15 1945

and that I last saw him alive on June 13 1945

Immediate cause of death	DURATION
Carcinomas Sigmoid	
Due to	
Due to	
Other conditions Thrombosis Coronary Artery (post operative) Partial Gastrectomy (Include pregnancy within 3 months of death) Intestinal Obstruction	

Major findings of operations .....

..... Date of op. .....

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John J Maloney M.D. M. D. or other

Address Cheverly Md Date signed 6-16-45


RECEIVED
JUN 19 1945
BUREAU V.A.


RECEIVED
JUN 19 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

0623:1

★ Reg. Dist. No. 245

1. PLACE OF DEATH:
County Pr Geo Co
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pr Geo Co
City or town Hyattsville md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3800 Nicholson st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ada Mae Bergling

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Sylvanus Bergling
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 21. 1891

8. AGE: Years	Months	Days	If less than one day
54			..... hrs. ..... min.

9. Birthplace (Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name Charles woodward
13. Birthplace mass.
MOTHER 14. Maiden name Ada mae Cinderson
15. Birthplace Md
16. Informant Margaret Bergling
Address Hyattsville Md
17. Burial (Burial, cremation, or removal. Which?) Buried Date thereof July 2. 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Colmar Manor Md
18. Funeral director F Gaeta Sons
Address Hyattsville Md.
19. July 2 1945 James Berry
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-28-45 19..... at 6 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1 19.45, to June 28 19.45
and that I last saw h.r alive on 6-28 19.45

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. Watts, Jr. M.D.
M. D. or other
Address Hyattsville, Md. Date signed 6-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

06240

Reg. Dist. No. 245

6

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred: Ileland Mem. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: WASH.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 111 - 7th ST N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: NELLIE M BEVINGTON

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

8.(b) Name of husband or wife: Thomas F Bevington
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept. 16 - 1870

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: Monticello, Iowa (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
12. Name of father: John McCannon
13. Birthplace of father: Boston, Mass.
14. Maiden name of mother: Sally A. Graham
15. Birthplace of mother: D.H.
16. Informant: Frank H. McCannon
Address: 111 - 7th ST N.E.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 18-45 (month) (day) (year)
Cemetery or crematory: Oakwood
Location: Monticello, Iowa
18. Funeral director: Jos. Gawler's Sons
Address: 1756 Pa. Ave NW Wash, D.C.
19. June 16 1945 James Sevey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1945 at 6:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to June 16 1945 and that I last saw h[illegible] alive on June 15 1945

	DURATION
Immediate cause of death: hepatitis with ascites	1 year
Due to: hypertensive cardiac disease	unknown
Due to: Arteriosclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry G Hadley M. D. or other
Address: 1252 16th St NW Date signed: June 16 45

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

C6241

Reg. Diat. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

How long in abeve place of death? 40 years

Hospital, Institution, or street address where death occurred: 511 - Addison Rd.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr Geo

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No. 511 Addison Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ralphael Louis Le Blanc.

3. (b) Social Security Number: 220-05-4253

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Annie LeBlanc

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): Sept. 4, 1864

8. AGE: Years	Months	Days	If less than one day
80.	9	4	hrs. ... min.

9. Birthplace: Hull Canada (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: House.

FATHER — 12. Name: Walter LeBlanc

FATHER — 13. Birthplace: Canada

MOTHER — 14. Maiden name: Adeline Lizotte

MOTHER — 15. Birthplace: Canada

16. Informant: Mrs Annie LeBlanc

Address: 511 Addison Rd S. Pleasant Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-11-45 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Bladensburg. Md.

18. Funeral director: U. H. Chambers Co.

Address: 517 11th St S.E.

19. June 9 1945 (Date rec'd by registrar) Gene A. Bonner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8 1945, at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945, to June 8 1945

and that I last saw him alive on June 7 1945

Immediate cause of death: Carcinomatosis of face with metastases

DURATION: 2 years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D. or other

Address: Capitol Hgts, Md. Date signed: 6/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06243

CERTIFICATE OF DEATH

★ Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: RURAL- Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr, 6 mo., 19 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 1 yr, 6 mo., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4709- 9th, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: BOOTH, PAUL

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 2, 1893

8. AGE: Years	Months	Days	If less than one day
52	3	18	hrs. min.

9. Birthplace: Walke Co., Indiana (Town, county, and state)
10. Usual occupation: none (crippled)
11. Industry or business: -

FATHER
12. Name: Orleando Booth
13. Birthplace: Decatur, Indiana

MOTHER
14. Maiden name: Rosetta Joy
15. Birthplace: Clinton, Indiana

16. Informant: decedent
Address:

17. Remarks (Burial, cremation, or removal, Which?) Date thereof June 29 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Deal Funeral Home
Address: 4812- 14th Ave. N.W. Washington, D.C.

19. June 19, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19, 1945, at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/30 1943, to 6/19 1945 and that I last saw h... alive on 6/19 1945

Immediate cause of death	DURATION
Tuberculosis	
Pulmonary	52 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Bilateral fibro-caseous
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed 6/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

(6242

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Georges
City or town Clinton Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years.
Hospital, institution, or street address where death occurred:
Clinton Md.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Clinton Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Sarah Alice Bowie

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 12 1874

8. AGE: Years 71 Months — Days — If less than one day — hrs. — min.

9. Birthplace Rockville Md.
(Town, county, and state)

10. Usual occupation Domestic.

11. Industry or business at home of Sister

FATHER
12. Name David H. Bowie
13. Birthplace Maryland.

MOTHER
14. Maiden name Winkelpor Kennelburger
15. Birthplace Maryland.

16. Informant Mrs. T. Allen Pumphrey
Address Clinton, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) 6-19-45

Cemetery or crematory Rockville Main

Location Rockville, Md.

19. Funeral director Wm Reuben Pumphrey

Address Rockville, Md.

19. 6/16/45 Thos. P. Griffith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 10½ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1945, to June 16 1945 and that I last saw her alive on June 15 1945

Immediate cause of death	DURATION
Acute myocardial degeneration	4 days
Due to Generalized Arteriosclerosis	autumn
Due to —	
Other conditions None of note	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Lewis Van Natta M. D. or other

Address Washington 19 DC Date signed June 16 1945.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

06244

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, Institution, or street address where death occurred:

Head on arrival Leland Memorial Hosp

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4106-46 Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nolan Burly

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Single

8.(b) Name of husband or wife: Child

8.(c) If alive, give age 11 years

7. Birth date of deceased (mo., day, yr.) July 5 1933

8. AGE:

Years	Months	Days	If less than one day
11	11	14	hrs. min.

9. Birthplace md (Town, county, and state)

10. Usual occupation a chore boy

11. Industry or business

FATHER 12. Name Kenneth Burly

13. Birthplace md

MOTHER 14. Maiden name Madeline Jackson

15. Birthplace md

16. Informant mother Madelinea Watkins

Address 607 8th Laurel md

17. Burial, Murkirk Md (Burial, cremation, or removal. Which?) Date thereof 6-24-45 (month) (day) (year)

Cemetery or crematory

Location Murkirk Md.

18. Funeral director J.B. Johnson

Address Marlboro Md.

19. June 22 1945 James Seery (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	
shock	
Due to Gun shot wound	
of head	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-21-45

Where did injury occur? Laurel P.G. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) In a woods

Means of injury shot with rifle Injured at work? no

Deputy medical Examiner

23. SIGNATURE ..... M. D. or other

Address ..... Date signed 6-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37a)

CERTIFICATE OF DEATH

016245

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Oxon Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, Institution, or street address where death occurred:

6601 - Oxon Hell Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Oxon Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6601 - Oxon Hell Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Fad Butler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Exact date of birth unknown

8. AGE: Years 105 | Months | Days | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Mathew Butler

13. Birthplace Maryland

MOTHER 14. Maiden name Cecilia Butler

15. Birthplace Maryland

16. Informant James F. Butler

Address Oxon Hill, Md.

17. (Burial, cremation, or removal. Which?) Date thereof June 8-1945 (month) (day) (year)

Cemetery or crematory Oxon Hill - SMd.

Location

18. Funeral director John F. Ahern & Co

Address 904 F St. S.W.

19. 6-6-1945 (Date rec'd by registrar) Thos J. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Cardiosclerosis	
Senile disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Forestville Md Date signed 6-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

T 06246

Reg. Dist. No. 232

1. PLACE OF DEATH:
County Prince George
City or town Melwood – Rural.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Melwood Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Emma G. Coffren

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife Julius E. Coffren
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 21-1858.

8. AGE: Years	Months	Days	If less than one day
87	4	16	..... hrs. ..... min.

9. Birthplace Collington, Md.
(Town, county, and state)
10. Usual occupation At home
11. Industry or business —

FATHER
12. Name Benjamin Lanham
13. Birthplace Unknown

MOTHER
14. Maiden name Ann M. Stewart
15. Birthplace Unknown

16. Informant Thomas L. Coffren
Address Melwood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-11-45. (month) (day) (year)
Cemetery or crematory Zenith.
Location Upper Marlboro, Md.

18. Funeral director T. Pitchie Bros.
Address Upper Marlboro, Md.

19. June 9 1945 A. Ewell Smith Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1943 to June 6 1945 and that I last saw h.. on alive on June 6 1945

Immediate cause of death	DURATION
Congestive Heart Failure	6 months
Due to Nephritis	6 yrs
Due to	
Other conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. —
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE James L. Jaffcoat M. D. or other
Address Upper Marlboro, Md. Date signed 6-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6247

Reg. Diat. No. 243.

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 17 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 423-9th St. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HAROLD HOMER COLEMAN

3.(b) Social Security Number: 578-14-7636

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married (Rep.)

6.(b) Name of husband or wife: Mattie S. Coleman
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): December 10, 1901

8. AGE: Years	Months	Days	If less than one day
43	6	6	...hrs. ...min.

9. Birthplace: Charlotte, Virginia
(Town, county, and state)
10. Usual occupation: Painter
11. Industry or business:

FATHER
12. Name: Julius Wesley Coleman
13. Birthplace: Virginia

MOTHER
14. Maiden name: Emma Smith
15. Birthplace: Virginia

16. Informant: Husband
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 17, 1945 (month) (day) (year)
Cemetery or crematory:
Location: to Phoenix, Va.
18. Funeral director: E. C. Moon By E. B. Canada
Address: Saxe, Va

June 16, 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16, 1945 at 3.55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1945, to June 16, 1945, and that I last saw him alive on June 15, 1945.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 6/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64a)

CERTIFICATE OF DEATH

Reg. Dist. No. 231 — 6248

1. PLACE OF DEATH:
County Prince Georges
City or town Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? years
Hospital, Institution, or street address (if not in hospital) where death occurred:
4106-46 Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Bladensberg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4106-46 Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lloyd Conway

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife Ramola Lillian Conway — 6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Nov 7, 1898

8. AGE: Years 46 | Months 7 | Days 14 | If less than one day hrs. min.

9. Birthplace Washington DC
(Town, county, and state)

10. Usual occupation Guard

11. Industry or business U. S. Department of Agriculture

FATHER
12. Name William Conway
13. Birthplace Upperville Va

MOTHER
14. Maiden name Ellie Carter
15. Birthplace Richmond, Va

18. Informant Ramola Lillian Conway
Address Bladensburg, Md

17. Burial — Date thereof June 24, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Methodist Cemetery
Location Bladensburg Md

18. Funeral director F Gaskie Lone
Address Bladensburg Md.

19. 6/23/45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 19 45 at 8 07 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
asphyxia	
Due to Hanging	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 6-21-45
Where did injury occur? Bladensburg (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Garage near home
Means of injury Hanging Injured at work? No

23. SIGNATURE James J. Ford M. D. or other
Deputy Medical Examiner
Address Forestville Md Date signed 6-21-45

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06249

★ Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 4 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2105 Nichols Ave., S. E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WALTER J. CORBIN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 28, 1904

8. AGE: Years	Months	Days	If less than one day
41	–	1	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business:

FATHER — 12. Name: Thomas Vincent Corbin

13. Birthplace: Fredericksburg, Virginia

MOTHER — 14. Maiden name: Jane Kane

15. Birthplace: Washington, D. C.

16. Informant: Decedent

Address:

17. (Burial, cremation, or removal. Which?) Removal — Date thereof (month) (day) (year) June 29 1945

Cemetery or crematory:

Location: to Washington, D. C.

18. Funeral director: Thomas F. Murray

Address: 2007 Nichols Ave. S.E.

19. (Date rec'd by registrar) June 29, 1945 — Registrar: Rowland S. Phillips

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1945, at 2.40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25 1945 to June 29 1945, and that I last saw h... alive on June 29, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 mo.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 6/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

06259

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Seat Pleasant 19 Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Geo.
City or town: Seat Pleasant 19 Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 303 69th Place
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Isaac Wellington Crawford Sr

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Margaret L. Crawford
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug. 14, 1881
8. AGE: Years 63 | Months 10 | Days 1 | If less than one day: ... hrs. 40 min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Insurance agent
11. Industry or business: Eureka Life Ins Co.
FATHER 12. Name: George L. Crawford
13. Birthplace: Maryland
MOTHER 14. Maiden name: Sarah E. Cope
15. Birthplace: Maryland
16. Informant: Margaret L. Crawford
Address: 303 69th St. Seat Pleasant Md
17. (Burial, cremation, or removal. Which) Date thereof: June 19, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md
18. Funeral director: C. S. Chamberlain
Address: 777 H St SE
19. 6-17-1945 Carrie Campbell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16, 1945, at 7.40 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1st 1945 to June 16th 1945
and that I last saw him alive on June 13th 1945
Immediate cause of death: Chronic Valvular heart disease — DURATION: One yr
Due to: Interstitial nephritis — 6 months
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Type of injury: Injured at work?

23. SIGNATURE: R. Akegar, M.D. or other
Address: Seat Pleasant Md. Date signed: June 16 45

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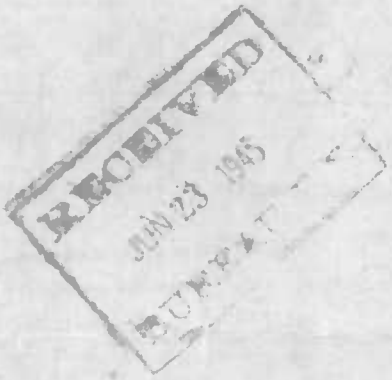
VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

06251

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Prince George General

How long in hospital or institution? 2 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Hall (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Robert Curtin

3.(b) Social Security Number:

4. Sex: male

5. Color or race: W

6.(a) Single, married, widowed, or divorced: newborn

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): ~~March~~ May 30 - 1945

8. AGE: Years: Months: Days: 2 If less than one day ... hrs. ... min.

9. Birthplace: Cheverly - Pr. Geo. Co. - Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Robert Curtin

13. Birthplace: Glendale Md

MOTHER 14. Maiden name: Doris Thames ~~[illegible]~~ 3/4/45

15. Birthplace: Bristol, Md

16. Informant: Mrs. Doris Thames Curtin

Address: Hall - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 3 1945 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: Anne Arundel Co.

18. Funeral director: Clarence Ferrace

Address: Mitchellville Md

19. 6/2 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2 1945, at 2:58 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Pulmonary hemorrhage	2 hrs
Due to: Patent ductus arteriosus	59 hrs 55'
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: J Francis Warren M.D. (M. D. or other)

Address: 1746 - K St. N.W. Date signed: 6/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C6252 Reg. Dist. No. 243

1. PLACE OF DEATH:
County Prince Georges
City or town RURAL- Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 23 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 month, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1635 - R. Street, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war -

3. (a) FULL NAME John D. Curtis
3. (b) Social Security Number 218-03-4764

4. Sex: male
5. Color or race: colored
6.(a) Single, married, widowed, or divorced: married (separated)
6.(b) Name of husband or wife: Annie Curtis
6.(c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) April 17, 1885
8. AGE: Years 60 Months 2 Days 7 If less than one day ... hrs. ... min.
9. Birthplace St. Mary's Co., Maryland (Town, county, and state)
10. Usual occupation janitor
11. Industry or business -
FATHER 12. Name Phillip Curtis
13. Birthplace St. Mary's Co., Md.
MOTHER 14. Maiden name Martha Barnes
15. Birthplace St. Mary's Co., Md.
16. Informant decedent
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof June 25, 1945 (month) (day) (year)
Cemetery or crematory
Location to Washington, D.C.
18. Funeral director Rowett Oabney
Address 2442 ... st ...
19. June 24 1945 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945, at 12:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1945, to June 24 1945
and that I last saw him alive on June 24 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	2 mo. 27 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D. (M. D. or other)
Address Glenn Dale, Md. Date signed 6/24/45

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06253

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: PRINCE GEORGES.
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs.
Hospital, institution, or street address where death occurred:
911 DAVIS AVE.
How long in hospital or institution? 17 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: PR. GEO.
City or town: Takoma Park,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 911 DAVIS AVE.
(If rurel, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: IDA EMMA DAVIS.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	WIDOWED

6.(b) Name of husband or wife: THOS. HENRY DAVIS
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MAY 3, 1865

8. AGE: Years	Months	Days	If less than one day
80	1	26	hrs. min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: ? ROOF.
13. Birthplace: ?

MOTHER
14. Maiden name: MARY KLOTZ
15. Birthplace: ?

16. Informant: MILLWARD TAFT.
Address: 239 WILLOW AVE. TAKOMA PARK, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: JULY 5, 1945 (month) (day) (year)
Cemetery or crematory:
Location: WHITE PLAINS, N.Y.

18. Funeral director: J. ARTHUR WALTERS
Address: 2514 CARROLL ST. TAKOMA PARK, D.C.

19. 6/29 19 45 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JUNE 29 1945 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1945, to June 29 1945 and that I last saw h[illegible] alive on June 28 1945

	DURATION
Immediate cause of death: Pneumonia (Lobar)	2 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. M. Stell, M.D. M. D. or other
Address: Silver Spring, Md. Date signed: 6/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06254

Reg. Diat. No. 242

1. PLACE OF DEATH:
County: Prince George's
City or town: Bladensburg Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, institution, or street address where death occurred:
1101-64 Pl.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Bladensburg Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1101-64 Pl.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Louis L. Davis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mittie Hester
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): 1872 (?)

8. AGE: Years: 73 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Oxford N C (Town, county, and state)
10. Usual occupation: Blacksmith
11. Industry or business
FATHER 12. Name: Phillip Davis
13. Birthplace: Oxford, N.C.
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Mrs. Hettie Davis
Address: 1101-64 Pl. (wife)
17. Burial (Burial, cremation, or removal, Which) Date thereof June 30 1945 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Washington, D. C.
18. Funeral director: Malvan F. Schey
Address: 424 R. St. N.W.
19. June 27 1945 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 19 45 at 1:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 19 45 to June 27 19 45
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hypertension	
Cardio vascular	?
Due to Disease,	
Due to	
Other conditions Debility	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H C Beddow M.D.
M. D. or other
Address 4423 Hunt Pl. N.E. Date signed 6-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

06256

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Brentwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hrs 30 minutes

Hospital, institution, or street address where death occurred:

Cedarcroft Sanitorium

How long in hospital or institution? 2½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Arlington

City or town Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1218 North Johnson

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Francis Donohue

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 13, 1889

8. AGE: Years 55 | Months 9 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Providence, R. I. (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business

FATHER — 12. Name Thomas Donohue

13. Birthplace Ireland

MOTHER — 14. Maiden name Catherine Gill

15. Birthplace Providence R. I.

16. Informant Mrs. Herbert L. Neyman 1218 North Johnson St

Address Arlington, Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 20. 1945 (month) (day) (year)

Cemetery or crematory P. A. Taltavull Funeral Home

Location 436-7th st S.W. Washington D.C.

18. Funeral director E. Gasch's Sons

Address Hyattsville Maryland.

19. June 20 1945 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1945, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Toxic Myocarditis	
Due to Acute and Chronic Alcoholism	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Hyattsville Md Date signed 6-20-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

CERTIFICATE OF DEATH

06255

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9030 Baltimore Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Bell Douglass

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Charles Douglass
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1861

8. AGE: Years: 84 Months: Days: If less than one day: hrs. min.

9. Birthplace: west Va
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

MOTHER
12. Name: Harriet Cox
13. Birthplace: west va

FATHER
12. Name: stephen Lovell
13. Birthplace: Penna

16. Informant: Bessie Newton Douglass
Address: Berwyn Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 29 1945 (month) (day) (year)
Cemetery or crematory: St Marys Cemetery.
Location: St Marys west Va

16. Funeral director: F. Gaska Son
Address: Hyattsville Md.

19. June 27th 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1945 at 9 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 1945 to June 26 1945 and that I last saw h[illegible] alive on June 19 1945.

	DURATION
Immediate cause of death: Cerebral thrombosis	2 wks.
Due to: General arteriosclerosis	10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. W. Nisbet MD
M. D. or other
Address: Beverly Md Date signed 6-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

06257

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Andrews Field, Washington 20, D. C.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? – –
Hospital, institution, or street address where death occurred:
Station Hosp, Andrews Field, Washington 20, DC
How long in hospital or institution? – –

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State – – County – –
City or town – –
(If outside city or town limits, write RURAL and give nearest town)
Street No. – –
(If rural, give LOCATION)
2.(a) If veteran, name war – –

3.(a) FULL NAME: DUNCAN JANE FRANCES

3.(b) Social Security Number: – –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	– – –

6.(b) Name of husband or wife – –
6.(c) If alive, give age – – years

7. Birth date of deceased (mo., day, yr.): 31 May 1945

8. AGE:

Years	Months	Days	If less than one day
– –	– –	1	10 hrs. 15 min.

9. Birthplace: Andrews Field, Washington 20, DC
(Town, county, and state)

10. Usual occupation – –

11. Industry or business – –

FATHER
12. Name: Charles Henry Duncan
13. Birthplace: Roanoke, Virginia

MOTHER
14. Maiden name: Jane Frances Coon
15. Birthplace: Roanoke, Virginia

16. Informant: Father: Major Charles H. Duncan
Address: Andrews Field, Washington 20, DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4 1945 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Arlington Cemetery

18. Funeral director: Wastler Funeral Home
Address: 301 E. Capitol St. Wash. DC

19. June 1- 1945 (Date rec'd by registrar) Sidney Goodman Capt. M.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 June 19 45, at 4:40 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from – – 19 – –, to – – 19 – –
and that I last saw h – – alive on – – 19 – –

Immediate cause of death: Atelectasis left lower lobe, complete; right lower lobe, patchy. Bronchopneumonia both lower lobes.
Due to: – –
Due to: – –
Other conditions: – –

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. – –
Autopsy results – –

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: David F. Conway
DAVID F. CONWAY, Major, MC M. D., or other
Address: Andrews Fld, Washington, DC Date signed: 6/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (R3)

CERTIFICATE OF DEATH

C6258

Reg. Dist. No. 231

1. PLACE OF DEATH: Pro Geo Co

County

City or town: Colmar Manor Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred: Eastern Branch of Potomac

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Pro Geo Co

City or town: Colmar Manor Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3311 - 40th Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Russell Franklin Estep, Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 1932.

8. AGE: Years	Months	Days	If less than one day
12	8	3	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: student

11. Industry or business

FATHER — 12. Name: Russell F. Estep sr.

FATHER — 13. Birthplace: Va

MOTHER — 14. Maiden name: Helen Campbell

MOTHER — 15. Birthplace: Va

16. Informant: Russell F. Estep sr

Address: Colmar Manor Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21, 1945 (month) (day) (year)

Cemetery or crematory: Mt Herman

Location: Woodstock Va

18. Funeral director: F Gaschi & Sons

Address: Hyattsville Md.

19. 6/21/45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1945, at 3:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to: Drowning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 6-19-45

Where did injury occur? Colmar Manor (City or town) Pr Geo (County) Md (State)

Injured at home, farm, industry, public place (where?) In Branch River

Means of injury: Drowning while (Injured at work?)

Deputy Medical Examiner

23. SIGNATURE: James J. Jones M. D. or other

Address: Forestville Md. Date signed 6-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06259

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince George
City or town Edmonston (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 5206 - 46th Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Edmonston (If outside city or town limits, write RURAL and give nearest town)
Street No. 5206 - 46 Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward Scott Franklin
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary A Franklin
6.(c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) Nov 25, 1876

8. AGE: Years 68 Months 6 Days 24 If less than one day ....hrs. ....min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Watchman
11. Industry or business

FATHER
12. Name Richard Franklin
13. Birthplace Virginia

MOTHER
14. Maiden name Susan Ann Brown
15. Birthplace Virginia

16. Informant Mary A. Franklin
Address Edmonston, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 19, 1945 (month) (day) (year)
Cemetery or crematory Handlon funeral Home
Location 641 H st N E DC

18. Funeral director F. Gasch's sons
Address Hyattsville Md

19. June 19, 1945 (Date rec'd by registrar) James Severy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1945 at 4:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h.... alive on ....19....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Cardiovascular renal disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death.)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy medical examiner

23. SIGNATURE James I. Boyd M. D. or other
Address Forestville Md Date signed 6-1945

VS A15

06260

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Diat. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Eugene Leland Memorial Hospital

How long in hospital or institution? 3 days-19 hrs. 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Brentwood.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3410 Varnum St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Theresa Freeman.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed.

6.(b) Name of husband or wife: Wm Carnell Freeman.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 4th 1867

8. AGE: Years	Months	Days	If less than one day
77	10	8	..... hrs. ..... min.

9. Birthplace: New York City.
(Town, county, and state)

10. Usual occupation: none.

11. Industry or business

FATHER
12. Name: Michael Casey
13. Birthplace: New York.

MOTHER
14. Maiden name: Catherine?
15. Birthplace: New York

16. Informant: patients daughter.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 14th 1945 (month) (day) (year)

Cemetery or crematory: Arlington Cemetery

Location: Arlington Va.

18. Funeral director: Wm J. Malley

Address: 3200-R.I. Ave. Mt. Rainier Md.

19. June 13 1945 James Devers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 1945 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1945, to June 12 1945 and that I last saw h.er alive on June 12 1945

Immediate cause of death	DURATION
Uremia	1 week
Due to: General arteriosclerosis	10 yrs
Due to:	
Other conditions: Bilateral	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

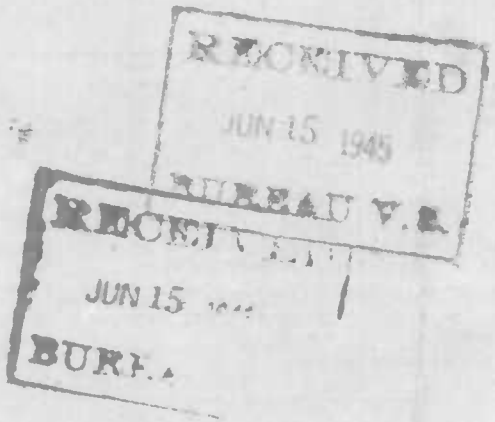
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: L.W. Malin M.D.
M. D. or other

Address: Riverdale, Md. Date signed: 6-12-45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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

06261

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 3 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1105- 7th St. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: David C. Gant

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 13, 1944

8. AGE:

Years	Months	Days	If less than one day
-	5	25	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: (Infant)

11. Industry or business:

FATHER
12. Name: Everett Gant
13. Birthplace: Suitland, Maryland

MOTHER
14. Maiden name: Rosetta Robinson
15. Birthplace: Washington, D. C.

16. Informant: Rosetta Gant, mother, 1105-7th St. S.E.
Address:

17. George A. Better Date thereof June 6, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Ralph H. Better
Location: Removal to Washington, D.C.

16. Funeral director: George A. Better
Address: 1203 Walter St. S.E.

19. June 7 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7 1945, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1945, to June 7 1945
and that I last saw h... alive on June 7 1945

Immediate cause of death	DURATION
Miliary Tuberculosis	5 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D.
M. D. or other
Address: Glen Dale, Md. Date signed: 6-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (193)

CERTIFICATE OF DEATH

06262

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? -

Hospital, institution, or street address where death occurred:

Eugene Leland Memorial Hosp

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4629 Baltimore Ave

(If rural, give LOCATION)

2.(a) If veteran, name war -

3.(a) FULL NAME Stephen Bernard Gray

3.(b) Social Security Number -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife -

6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) July 14, 1913

8. AGE: Years: 31 | Months: 11 | Days: | If less than one day: hrs. min.

9. Birthplace: Mt. Rainier Md (Town, county, and state)

10. Usual occupation: Tree Trimmer

11. Industry or business: Tree Trimming

FATHER — 12. Name: Benjamin L Gray

FATHER — 13. Birthplace: Hyattsville Md.

MOTHER — 14. Maiden name: Irene Veronica (Brunswell) Brunswell

MOTHER — 15. Birthplace: Washington, Dc

16. Informant: mother - Mrs. Irene V. Gray

Address: Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 30. 1945 (Month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Colmar Manor Md

18. Funeral director: F. Gasch's sons

Address: Hyattsville Md

19. June 28 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Shock	
Due to: Electrocution	
Due to: Cause is Contact with high power wire	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 6-27-45

Where did injury occur? Largo (City or town) P.G. (County) Md (State)

Injured at home, farm, industry, public place (where?) Work

Means of injury: Came in contact with high power wire Injured at work? Yes

Deputy medical Examiner

23. SIGNATURE: James J. Boyle M. D. or other

Address: Hyattsville Md Date signed: 6-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age

T 06263

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92b)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges County

City or town: Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
Prince Georges General Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3333 - 11th Street S. E. Washington D. C.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Gregory. Teresa A.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Raymond V. Gregory

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12 1899

8. AGE: Years: 45 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: N Y.
(Town, county, and state)

10. Usual occupation: H W.

11. Industry or business:

FATHER
12. Name: Mr. William Milen
13. Birthplace: Canada

MOTHER
14. Maiden name: Anna Tower
15. Birthplace: Canada

16. Informant: Husband
Address:

17. Burial — Date thereof 6/5/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md.

16. Funeral director: Chas. F. Murray

Address: 2007 - Nichols Ave. S.E.

19. 6/2 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2 1945 at 1:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 1935 to June 2 1945
and that I last saw him alive on June 2 1945

Immediate cause of death	DURATION
Fibral pleurisy	
Due to: Cause Unknown	
Due to:	
Other conditions: Bronchitis chronic	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. Watts M.D.
M. D. or other

Address: Hyattsville Md. Date signed: 6-2-45

Is especially important. Physician please write the cause of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06264

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Mothers Jones Rest Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1444 V. St. N.W. Wash. D. C.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Oscar H. Griffith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lula Upwright
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 13 1881

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: W. Va
(Town, county, and state)
10. Usual occupation: Scientific aide
11. Industry or business: U.S. Govt.
FATHER 12. Name: unknown
13. Birthplace: unknown
MOTHER 14. Maiden name: unknown
15. Birthplace: unknown
16. Informant: Anna C. Totura
Address: 1616 Newton St. N.W. Wash. D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 14 1945 (month) (day) (year)
Cemetery or crematory: Bolivar Cemetery
Location: Harpers Ferry, W. Va
18. Funeral director: R. H. Chambers Co.
Address: Riverdale, Md.
19. June 11 1945 James Seery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1945 at 8:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-22-45 1945 to 6-10-45 1945 and that I last saw h. alive on 6-9-45 1945

Immediate cause of death	DURATION
Coronary Thrombosis	3 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John P. Clum M.D.
M. D. or other
Address: Hyattsville Md. Date signed: 6-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186)

06265

CERTIFICATE OF DEATH ★

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges

City or town Mitchellville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

on J. N. Jerrys' Farm

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Mitchellville

(If outside city or town limits, write RURAL and give nearest town)

Street No. J. N. Jerrys Farm

(If rural give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Franklin D. Hamilton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1942

8. AGE:

Years	Months	Days	If less than one day
2	9	26	..... hrs. ..... min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER

12. Name William James Hamilton

13. Birthplace Maryland

MOTHER

14. Maiden name Lucy Harper

15. Birthplace Maryland

16. Informant Mrs. Lucy Hamilton

Address Mitchellville Md

17. burial Date thereof June 20 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Family

Location Mitchellville Md

18. Funeral director Clarence Forcare

Address Mitchellville Md

19. June 19 19 45 Louise H Peach

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945 at 7:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Crushed Skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 6-18-45

Where did injury occur? Mitchellville Pr. Geo Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Farm

Means of injury Crushed under a wheel Injured at work? No

Deputy Medical Examiner

23. SIGNATURE Lawrence J. Bond M. D. or other

Address Forestville Md Date signed 6-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (931)

06266

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:
County: Pr George Co
City or town: 4914 Livingston Rd. SE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Chas. Co.
City or town: Dentsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Hancock

3.(b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: James ~~Jas~~ Marshall Hancock
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Mch 9. 1882
8. AGE: Years 63 | Months | Days | If less than one day ... hrs. ... min.
9. Birthplace: Chas Co.
(Town, county, and state)
10. Usual occupation: HW
11. Industry or business
FATHER 12. Name: Francis Cox
13. Birthplace: Wash DC
MOTHER 14. Maiden name: ? Murphy
15. Birthplace: Chas Co.
16. Informant: Agnes J. Dyer
Address: 4914 Liv. Rd S.E. Wash DC
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-29-45 (month) (day) (year)
Cemetery or crematory: Dentsville MD
Location: Dentsville Md
18. Funeral director: Hewitt & Ryan
Address: Waldorf Md
19. June 26 1945 (Date rec'd by registrar) Mrs. Alton Davis Registrar

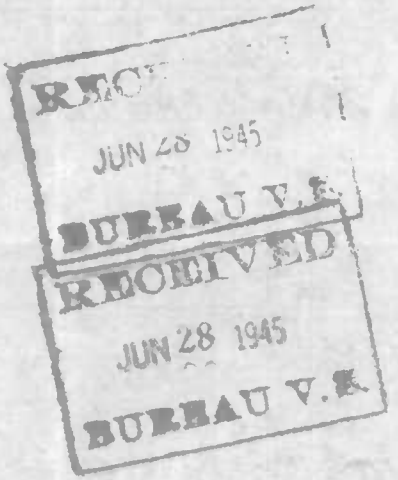
MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1945, at 4:00 am
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1945, to June 26 1945 and that I last saw her alive on June 25 19

Immediate cause of death: Myocarditis | DURATION
Due to: Arteriosclerosis / Hypertension | 7 yr
Due to: Ascites
Other conditions: Old Cerebral Hem | 2 yr
Pyelo-nephritis + cystitis
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: E. W. Stewart, M.D. (M. D. or other)
Address: 1225 Talbot Av SE, Wash, (20) D.C.
Date signed: 6/26/45


JUN 28 1945
BUREAU V.E.
RECEIVED
JUN 28 1945
BUREAU V.E.

Evidence for change of age is shown on G 96 JUN 23 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-2)

CERTIFICATE OF DEATH

06267 ★ Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince Geo
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Hathcock

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 17 43

8. AGE: Years: 21 | Months: 11 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: J W Hathcock
13. Birthplace: Norwood N C

MOTHER
14. Maiden name: Dorothy Mitchell
15. Birthplace: New York City

16. Informant: J. W. Hathcock
Address: Laurel Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: June 13 45 (month) (day) (year)
Cemetery or crematory: Dog Hill
Location: Laurel
18. Funeral director: Lloyd Lauer
Address: Laurel Md

19. June 13 1945 (Date rec'd by registrar) Cora E. Wachter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945, at 5 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 6 1945, to June 11 1945, and that I last saw him alive on June 11 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to: Cerebral Birth injury	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B Adams M. D. or other
Address: Date signed:

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (1) MARGIN RESERVED FOR BINDING (M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

106268

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: (Rural) Glenn Dale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 3 mos., 30 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 3 yrs., 3 mos., 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 316 - 5th St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: VERA M. HICKS

3.(b) Social Security Number: 579-12-3370

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Robert J. Hicks
6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): April 19, 1920

8. AGE: Years	Months	Days	If less than one day
25	2	4	hrs. min.

9. Birthplace: Naples, Italy (Town, county, and State)
10. Usual occupation: Clerk
11. Industry or business:

FATHER
12. Name: Joseph Steriale
13. Birthplace: Italy

MOTHER
14. Maiden name: Carmella Steriale
15. Birthplace: Italy

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: June 3, 1945 (mouth) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Wm. J. Lee & Sons.
Address: 300 4th St. N.E.

19. June 3, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3, 1945, at 12 Noon

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 4, 1942 to June 3 1945
and that I last saw h.er alive on June 3 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3½ yrs.
Complications:	
Due to: Bronchio-pleural fistula & right tuberculous empyema	3 yr 1 mo.
Amyloidosis liver & kidneys	8 mo.
Tuberculous peritonitis	1 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 6/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-b)

06269

CERTIFICATE OF DEATH ★

Reg. Dist. No. 243.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: RURAL- Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 1 mo., 16 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 1 mo., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2448- Ontario Rd., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: no ✓

3.(a) FULL NAME Mildred Virginia Hill Hill

3.(b) Social Security Number 577-30-6149

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): November 27, 1923

8. AGE: Years: 21 | Months: 6 | Days: - | If less than one day: ____ hrs. ____ min.

9. Birthplace: South Boston, Virginia (Town, county, and state)
10. Usual occupation: domestic
11. Industry or business:
FATHER 12. Name: Charles Hill
13. Birthplace: not known
MOTHER 14. Maiden name: Willy Easley
15. Birthplace: South Boston, Virginia
16. Informant: decedent
Address:
17. Removal to (Burial, cremation, or removal. Which?) Date thereof: June 26, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Thomas Frazier Co.
Address: 389- R. I. Ave. N.W.
19. June 26 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1945, at 6 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 10 1944, to June 26 1945,
and that I last saw h. alive on June 26 1945.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	14 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: June 6, 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06270

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: (rural) Glenn Dale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 11 mos., 30 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 11 mos., 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1322 U St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME Rufus Horton Jr

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) August 22, 1940

8. AGE: Years	Months	Days	If less than one day
4	9	25	hrs. min.

9. Birthplace: Washington D.C.

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Rufus Horton

13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Julia E. Moses

15. Birthplace: North Carolina

16. Informant: Rufus N. Horton (Father)

Address: 1322 U St. N.W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 17, 1945 (month) (day) (year)

Cemetery or crematory: Washington Nat.

Location: D.C.

18. Funeral director: R.N. Horton

Address: 1322 you St N.W. D.C.

19. June 16 1945 Rowland A Phillips

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1945, at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1943, to June 16 1945, and that I last saw h.. alive on June 16 1945

	DURATION
Immediate cause of death: Attempt at Spine Fusion	
Pulmonary Tuberculosis	28 mo.
Contrib. Tuberculosis of spine	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 6.16.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06271

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges County

City or town Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years 7 months 29 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 16 years 7 month 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Mrs. Augusta Hove

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	X

6.(b) Name of husband or wife Rice H. Hove

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4-1880

8. AGE: Years	Months	Days	If less than one day
65	3	16	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Edward M. McGruder

13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth M. Mullikin

15. Birthplace Maryland

16. Informant J. B. McGruder

Address Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 (month) 22 (day) 45 (year)

Cemetery or crematory St Thomas

Location Croom Maryland

18. Funeral director Ritchie Bros

Address Upper Marlboro Md

19. 6/20 (Date rec'd by registrar) 19 45 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 45, at 7.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 45, to June 20 19 45

and that I last saw her alive on June 19 19 45

Immediate cause of death	DURATION
Congestive Heart failure	3 days
Arteriosclerotic Brain	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Thomas V Collins M. D. or other

Address 322 H St NE Date signed June 20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

06272

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Georges
City or town 5257 St Barnabas Road (If outside city or town limits, write RURAL and give nearest town)
Walker Mill
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince George
City or town Capitol Hill (If outside city or town limits, write RURAL and give nearest town)
Street No. 5257 St. Barnabas Rd (If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Samuel Tarleton Hunter

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife Essena Hunter
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Aug. 14, 1866

8. AGE: Years	Months	Days	If less than one day
78			..... hrs. ..... min.

9. Birthplace Alexandria Va (Town, county, and state)
10. Usual occupation None
11. Industry or business None
FATHER 12. Name Joseph Hunter
13. Birthplace Va
MOTHER 14. Maiden name Mollie Edlin
15. Birthplace Md
16. Informant Miss Edith Walters
Address 103 Kennedy St. N.W.
17. Buried (Burial, cremation, or removal. Which?) Date thereof June 7, 1945 (month) (day) (year)
Cemetery or crematory St Johns
Location Clinton, Md
18. Funeral director W. W. Chambers Co
Address 517 - 11th St. S.E.
19. 6-5-45 (Date rec'd by registrar) Thos. S. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at 8 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1945 to June 4 1945
and that I last saw him alive on June 4 1945
Immediate cause of death Acute Coronary disease (Angina Pectoris) — DURATION 1 day
Due to Chronic myocarditis and — DURATION 5 years
Due to General Arteriosclerosis — DURATION
Other conditions —
(Incinde pregnancy within 3 months of death)
Major findings of operations none — Date of op. none
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury none Injured at work? none
23. SIGNATURE Paul C. Van Natta M. D. or other
Address Washington 19 DC Date signed June 5 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06273

CERTIFICATE OF DEATH ★

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: RURAL- Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo., 18 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington, D. C
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3820- 31st. St., Mt. Ranier, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Anastasia Ingersoll

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Eugene Ingersoll
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec., 22, 1908

8. AGE: Years	Months	Days	If less than one day
36	6		hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: dressmaker
11. Industry or business: -

FATHER
12. Name: Paul Barikalff
13. Birthplace: Russia

MOTHER
14. Maiden name: Theodosia Lareonosa
15. Birthplace: Russia

16. Informant: decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof JUNE 22 1945 (month) (day) (year)
Cemetery or crematory: to Wash. D.C.
Location:
18. Funeral director: W W Chambers Co
Address: 517-11 St SE.
19. June 22 19 45 Rowland S. Phillips (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 19 45, at 11:25 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4 19 45, to June 22 19 45
and that I last saw her alive on June 22 19 45

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	8 yrs 4 mos
Due to: Tuberculous Enteritis	6 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M D (M. D. or other)
Address: Glenn Dale, Md. Date signed: June 22, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

46274

Reg. Dist. No. 243

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Prince George
City or town Bowie Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince Geo.
City or town Bowie Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Noah Joffe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Joffe
6(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) 9-16-1902

8. AGE:

Years	Months	Days	If less than one day
42	8	16	hrs. min.

9. Birthplace Bowie Md
(Town, county, and state)
10. Usual occupation Merchant
11. Industry or business General Mdse
FATHER 12. Name Simon Joffe
13. Birthplace Russia
MOTHER 14. Maiden name Rebecca Tucker
15. Birthplace Russia
16. Informant David Joffe
Address 2326 Kelaware Balto Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-3-45 (month) (day) (year)
Cemetery or crematory Hebrew Cemetery
Location Annapolis Md.
18. Funeral director Jack Lewis Inc
Address 1409 E. Balto St. Balto Md
19. June 2 1945 Mrs. J.W. Giangrieg
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 1205 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1943, to June 2 1945 and that I last saw him alive on June 2 1945.

Immediate cause of death	DURATION
Coronary thrombosis	2 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert J McElroy M.D.
M. D. or other
Address 407 Main St Laurel Md Date signed 6/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

06275

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: (Rural) Glenn Dale, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 4 mos., 26 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 4 yrs., 4 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits write RURAL and give nearest town)

Street No. 17 D. Street S. E.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: JONES, JULIA CATHERINE

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): December 17, 1890

8. AGE: Years	Months	Days	If less than one day
54	5	18	... hrs. ... min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: —

FATHER — 12. Name: Franklin Jones

13. Birthplace: St. Mary's Co. Md.

MOTHER — 14. Maiden name: Louella Cobb

15. Birthplace: St. Mary's Co., Md.

16. Informant: Deceased

Address:

17. (Burial, cremation, or removal. Which?) Removal to Date thereof (month) June 4 (day) (year) 1945

Cemetery or crematory: Washington D.C.

Location:

19. Funeral director: George B Clarke

Address: 1416 Fla. Ave N.E.

19. (Date rec'd by registrar) June 4 1945 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1945 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/9/1941, to 6/4/1945

and that I last saw her alive on 6/4/1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yr. 7 mos.
Due to: Syphilis	4 yrs. 3 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed: 6/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

06276

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 6307 - 46th Avenue
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 30 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Riverdale Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 6307 - 46th Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Veronica Marie Krauss

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Karl A. Krauss, Sr.
6(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1891

8. AGE: Years	Months	Days	If less than one day
54	4	21	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Thomas Lynch
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Harris
15. Birthplace: Ireland

16. Informant: Karl A. Krauss, Sr.
Address: 6307 - 46th Ave. Riverdale, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: June 14th 1945
(month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Bladensburg Rd. & D.C. Line
18. Funeral director: Wm. J. Hally
Address: 3200 - Rhode Island Ave. Mt. Rainier Md.

19. June 13 1945
(Date rec'd by registrar)
James Bevers
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 1945, to June 11 1945, and that I last saw her alive on June 8 1945.

	DURATION
Immediate cause of death: Coronary Occlusion	30 mins.
Due to: Coronary Artery Disease	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Charles C. Hageage M.D.
M. D. or other
Address: Mt. Rainier, Md. Date signed: June 11, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06277

Reg. Dist. No. 1232

1. PLACE OF DEATH
County Prince George's
City or town Dodge Station Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Dodge Station Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nora Ellen Lanty

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Luther G. Lanty
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Jan. 17-1900

8. AGE: Years 45 | Months 5 | Days 2 | If less than one day ... hrs. ... min.

9. Birthplace Millwood District Pr. Geo. Co. Md.
(Town, county, and state)
10. Usual occupation At home
11. Industry or business

FATHER
12. Name Richard H. Tayman
13. Birthplace Pr. Geo. Co., Md.

MOTHER
14. Maiden name Mary E. De Vaughn
15. Birthplace Pr. Geo. Co., Md.

16. Informant Luther G. Lanty
Address Upper Marlboro, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 6-22-45 (month) (day) (year)
Cemetery or crematory Trinity
Location Upper Marlboro, Md.

18. Funeral director Ritchie Brothers
Address Upper Marlboro Md.

19. June 21 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-19 1945 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to June 19 1945 and that I last saw her alive on June 19 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 hours
Due to Nephritis	3 yrs
Due to Arteriosclerosis	5 yrs
Other conditions Menopause	1 yr

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James E. Saucer M. D. or other
Address Upper Marlboro, Md. Date signed 6-21-45

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

06278

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: RURAL- Glenn Dale, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mo., 18 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 9 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1439- 22d, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary Edith Lanham

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Herbert E. Lanham
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): January 27, 1882

8. AGE: Years	Months	Days	If less than one day
63	4	23	..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: -

FATHER
12. Name: George T. French
13. Birthplace: unknown

MOTHER
14. Maiden name: Anne Adams
15. Birthplace: Washington, D. C.

16. Informant: decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 19, 1945 (month) (day) (year)
Cemetery or crematory
Location: Washington, D. C.
18. Funeral director: Wm. J. Dailey
Address: 522 8th St. S.E.
19. June 19, 1945 (Date rec'd by registrar) Rowland L. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19, 1945, at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1, 1944, to June 19, 1945 and that I last saw h.r. alive on June 19, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	4 yrs 8 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 6/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06279

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Geoge's
City or town: (rural) Glenn Dale, Maryland
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 14 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 603 – 7th St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Richard Mack

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mildred L. Mack
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): Jan. 5, 1909

8. AGE: Years	Months	Days	If less than one day
36	4	30	..... hrs. ..... min.

9. Birthplace: Chicago, Illinois (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business:
FATHER 12. Name: Samuel J. Mack
13. Birthplace: Chicago, Illinois
MOTHER 14. Maiden name: Rose Sandusky
15. Birthplace: Chicago, Illinois
16. Informant: Decedent
Address:
17. Removal to (Burial, cremation, or removal. Which?) Date thereof: June 4, 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
16. Funeral director: Albert Ashe
Address: 641 – H. St. N. E.
19. June 4 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1945, at 10:40 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1945, to June 4 1945
and that I last saw h.../.ive alive on June 4, 1945

Immediate cause of death

	DURATION
Pulmonary Tuberculosis	3 yrs 5 mo
Due to: Tuberculous enteritis	2 mo
Due to: Tuberculous laryngitis	2 mo
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 6/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06280

Reg. Dist. No. 2140

1. PLACE OF DEATH:
County: Prince Geo Co
City or town: Rural Brandywine md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Geo Co
City or town: Rural Brandywine Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Milton R. Mahoney

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M ~~F~~	Col	Married

6.(b) Name of husband or wife: Nora
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mch 25 - 1883

8. AGE: Years	Months	Days	If less than one day
62	2	9	..... hrs. ..... min.

9. Birthplace: Waldorf md (town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: George Mahoney
13. Birthplace: Charles Co
MOTHER 14. Maiden name: Gaynett Penn
15. Birthplace: Chas Co Md
16. Informant: Nora Mahoney
Address: Brandywine Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 8 1945 (month) (day) (year)
Cemetery or crematory: Asberry
Location: Rural Waldorf Md
18. Funeral director: Hewitt & Ryon
Address: Waldorf Md
19. June 7 1945 — M C Howard (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4. 1945 at 7:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1937 to June 1 1945 and that I last saw h~~im~~ alive on 6/11 1945

Immediate cause of death	DURATION
Cerebral Apoplexy	
Due to: Cardio - Vas -	
Due to: Renal Dis -	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

~~22.~~ VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Chas D. Worden M. D. or other
Address: Waldorf Md Date signed: 6/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06281

CERTIFICATE OF DEATH

Reg. Dist. No. 239

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:

County Prince Georges

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Georges

City or town Laurel, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rose E Matthews

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Thomas Matthews

6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Sept 3 188[illegible]

8. AGE: Years	Months	Days	If less than one day
64	9	2	..... hrs. ..... min.

9. Birthplace Howard Co Md (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name John Levi

13. Birthplace Howard Co Md

MOTHER 14. Maiden name Harriet H[illegible]

15. Birthplace Anne Arundel Co

16. Informant Thomas Matthews

Address Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8 1945 (month) (day) (year)

Cemetery or crematory Asbury Cemetery

Location Asbury Howard Co. Md

18. Funeral director Ridgely Sellers

Address 401 Washington Ave Laurel Md

19. June 7 1945 Cora E. Wachter Deputy Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1945, to June 5 1945 and that I last saw her alive on June 5 1945

	DURATION
Immediate cause of death Hypostatic	2 days
Due to Pneumonia	
Due to Hemiplegia	
Due to Cerebral Hemorrhage	6 Mos
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major operations of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J M Warren M.D. M. D. or other

Address Laurel Md Date signed 6-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1248)

06282

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:

County: Prince Geo.

City or town: Branchville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Prince Geo.

City or town: Branchville (If outside city or town limits, write RURAL and give nearest town)

Street No.: 9014 - R.D. 1 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Letitia E. McIntyre

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6/6/1892

8. AGE: Years: 53 | Months: 0 | Days: 18 | If less than one day: hrs. mio.

9. Birthplace: D.C. (Town, county, and state)

10. Usual occupation: at home

11. Industry or business:

FATHER 12. Name: John H. McIntyre

13. Birthplace: D.C.

MOTHER 14. Maiden name: Frances Williams

15. Birthplace: D.C.

16. Informant: Reed McIntyre

Address:

17. Burial (Burial, cremation, or removal, which?) Date thereof: 6/27/45 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Bladensburg Md.

18. Funeral director: J. W. Lee & Sons

Address: 1300 - 4th NE - DC

19. 6/25 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 28 1945, to Jun 24 1945 and that I last saw h... alive on Jun 23 - 1945

Immediate cause of death	DURATION
Cerebral Lues	6 F
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: 6/25/45

VS A15

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06283

Reg. Diat. No. 242

1. PLACE OF DEATH:
County: Prince Georgis
City or town: Hillside Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georgis
City or town: Hillside
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1406 60th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Kelly McLewis

3.(b) Social Security Number: 577-03-5070

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah Mary McLewis
6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.): July 4th 1878

8. AGE:

Years	Months	Days	If less than one day
66	11	6	2 hrs. — min.

9. Birthplace: Glascow Scotland
(Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: Preparing meals
FATHER 12. Name: John McLewis
13. Birthplace: Scotland
MOTHER 14. Maiden name: Sarah Bell
15. Birthplace: Paris-France
18. Informant: Mrs Sarah Mae Lewis
Address: 1406 60th Ave, Hillside Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-14-45 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Bladensburg, Md.
18. Funeral director: W. W. Chambers Co.
Address: 517 11th St S. E.
19. June 12 1945 (Date rec'd by registrar) Irene A. Bonner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11th 1945, at 10:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12th 1944, to July 11th 1945
and that I last saw h[illegible] alive on July 11th 1945

Immediate cause of death: Arteriosclerosis — Duration: Indefinite
Due to: Age
Due to: —
Other conditions: Anaemia - Chronic Interstitial Nephritis — Duration: 7 mo.
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Arthur N Meloy M. D. or other
Address: 4400 Bowen Rd SE Date signed 6-11-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

T

VS A15

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

06284

Reg. Dist. No. 195

FILM IV G96 JUN 21 1945

1. PLACE OF DEATH:

County: Prince George's

City or town: Brentwood (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred: Brentwood Sanitarium

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Prince George's

City or town: Same (If outside city or town limits, write RURAL and give nearest town)

Street No. 516 Prince George's St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas Andrew Mason

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of ~~husband~~ or wife: Lydia Mason

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 4 1862

8. AGE: Years: 82 | Months: 8-3- | Days: 11 | If less than one day: 4 hrs. ..... min.

9. Birthplace: U.S. Prince Md. (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business: U.S. Government Printing Office

FATHER 12. Name: James Mason

13. Birthplace: Africa

MOTHER 14. Maiden name: Julia Whitehead

15. Birthplace: Va. Co.

16. Informant: Theodore Thompson

Address: Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 11, 1945 (month) (day) (year)

Cemetery or crematory: Lincoln Park

Location: Baltimore, Md.

18. Funeral director: Wm. H. Hamilton

Address: Laurel, Md.

19. 6/9/45. 19..... Frank S. Shipley Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7th 1945, at 11:00 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2nd 1945, to June 7th 1945, and that I last saw him alive on June 7th 1945.

	DURATION
Immediate cause of death: Cerebral hemorrhage	24 hrs.
Due to: Cerebral arteriosclerosis	Unknown
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Harris M. Stewart M. D. M. D. or other

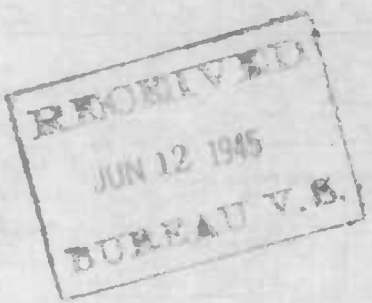
Address: Brentwood Sanatorium Date signed: June 8, 1945.

Brentwood, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
JUN 12 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06285 243.
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince Georges Co.
City or town: Rural- Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 14 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3120- 20, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Edward R. Montague

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1915

8. AGE: Years	Months	Days	If less than one day
30	3	26	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: auto mechanic
11. Industry or business: –

FATHER
12. Name: Zebedee Montague
13. Birthplace: Wash., D.C.

MOTHER
14. Maiden name: Lenora Simms
15. Birthplace: Wash., D. C.

16. Informant: decedent
Address

17. (Burial, cremation, or removal. Which?) Removal to Date thereof (month) (day) (year) June 27, 1945
Cemetery or crematory
Location: Washington, D.C.
18. Funeral director: Robert G. Mason
Address: 2500 Nichols Av. S.E.

19. (Date rec'd by registrar) June 27 1945 Registrar: Rowland J. Phillips

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1945, at 11 15/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 13, 1945, to June 27 1945
and that I last saw h.im alive on June 27 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 6-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

06286

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: East Riverdale Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred:
5906 - Sheridan Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: East Riverdale Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5906 - Sheridan St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME [redacted] Leila Marie Nelson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Lawrence Nelson
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Feb 14, 1893

8. AGE: Years	Months	Days	If less than one day
52	4	10	..... hrs. ..... min.

9. Birthplace: Iowa (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: John Muth
FATHER 13. Birthplace: Iowa
MOTHER 14. Maiden name: Mary Walker
MOTHER 15. Birthplace: Iowa
16. Informant: Lawrence Nelson
Address: East Riverdale Heights, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27, 1945 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Colmar Manor, Md
18. Funeral director: J. Gascha Sons
Address: Hyattsville Md
19. June 25, 1945 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945 at 8:20 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner James F. Ford M.D. or other
Address: Forestville Md Date signed 6-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06287

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Pro Geo Co.
City or town Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland, County Pro Geo Co
City or town Eastpines Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6314 Powhatan st
(If rural, give LOCATION)
2.(a) If veteran, name war None.

3.(a) FULL NAME John Joseph Nokes

3.(b) Social Security Number 577-09-9267.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Esther V. Nokes
6.(c) If alive, give age 46. years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1904

8. AGE: Years	Months	Days	If less than one day
41			..... hrs. ..... min.

9. Birthplace N. H.
(Town, county, and state)
10. Usual occupation machinist
11. Industry or business Engineer & Research corp.
FATHER 12. Name John wm. Nokes
13. Birthplace England
MOTHER 14. Maiden name Jane Stanfield
15. Birthplace England
16. Informant Agnes Nokes
Address Riverdale Md.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof June 14. 1945 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland Md.
18. Funeral director F Gaschi sons
Address Hyattsville Md
19. June 14 1945 (Date rec'd by registrar) James Dewey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945 at 7:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-8 1945 to 6-11-45 and that I last saw h. 12 alive on 6-11-45

Immediate cause of death	DURATION
Pulmonary hemorrage	
Pleuritic Tuberculosis	8 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John P. Clem M.D. M. D. or other
Address Hyattsville Md Date signed 6-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0628

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: RURAL- Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo., 6 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 mo., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1133- 5th, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: JACK OTT

3.(b) Social Security Number: 577-12-6884

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Susie B. Ott (alive)

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Dec. 13, 1911

8. AGE: Years	Months	Days	If less than one day
33	6	8	hrs. min.

9. Birthplace: Bowman, Dorchester Co., S.Carolina
(Town, county, and state)

10. Usual occupation: Operator of press machine, metals

11. Industry or business: -

FATHER
12. Name: Harry Ott
13. Birthplace: Bowman, Dorchester Co., S.Carolina

MOTHER
14. Maiden name: Essie Milde
15. Birthplace: Roseville, S. Carolina

16. Informant: decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/22/45 (month) (day) (year)

Cemetery or crematory: Washington town

Location: D. C.

18. Funeral director: Smith Dabney

Address: 442- M st.

19. June 21, 1945 (Date rec'd by registrar) Rowland S. Phibbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21, 1945, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15, 1945, to June 21 1945

and that I last saw him alive on June 20 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 5 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed: 6/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

(628)

Reg. Dist. No. 231

1. PLACE OF DEATH

County: Pro Geo Co

City or town: Adrucktown md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md County: Pro Geo Co

City or town: Greenbelt md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 g Hillside Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sandra Elaine Parsons

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 28. 1944

8. AGE: Years: 1 | Months: 2 | Days: | If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Thomas E Parsons

13. Birthplace: N. H.

MOTHER — 14. Maiden name: Donna Conner

15. Birthplace: Missouri

16. Informant: Thos E Parsons

Address: 14 g Hillside Greenbelt md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8. 1945 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Bladensburg md

18. Funeral director: F Gaede Sons

Address: Hyattsville md

19. 6/7 1945 (Date rec'd by registrar) Amanda Dawney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6. 1945, at 1:35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 1945, to June 6 1945 and that I last saw h[illegible] alive on June 3 1945

Immediate cause of death	DURATION
Cerebral Spinal Sclerosis	14 mo
Due to:	
Due to:	
Other conditions: Mayor convulsions, Mental Retardation (Include pregnancy within 3 months of death)	14 mo.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John D. Maloney M. D. or other

Address: Hyattsville md Date signed: 6-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-2)

CERTIFICATE OF DEATH

06290

Reg. Dist. No. 230

6

1. PLACE OF DEATH:
County: Prince Geo
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6/21/45 (1 day)
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md County: Pr Georges
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No. 18-D
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Louis Byron Pearce

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Sudie Hall
6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): 2/5/1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69	5	17		

9. Birthplace: Scotts Hill N.C. (Town, county, and state)
10. Usual occupation: owner of business
11. Industry or business: groceries
FATHER 12. Name: Louis C. Pearce
FATHER 13. Birthplace: Scotts Hill N.C.
MOTHER 14. Maiden name: Unn
MOTHER 15. Birthplace: Scotts Hill N.C.
16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 (month) 23 (day) 45 (year)
Cemetery or crematory: Ch. Cemetery
Location: Scotts Hill, N.C.
18. Funeral director: Lee Chambers
Address: Riverdale, Md
19. June 23 1945 (Date rec'd by registrar) James Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22nd 1945, at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22, 19 A.M. 1945, to 19
and that I last saw h.. alive on June 22, 1 P.M. 1945

Immediate cause of death	DURATION
Dissecting aneurysma of aorta	8 hrs
Due to: Arteriosclerosis	5 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hans Wodda, M.D. M. D. or other
Address: 30-D Ridge Rd Greenbelt, Md Date signed: 6-22-45

M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-a)

CERTIFICATE OF DEATH

06291

Reg. Diat. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 Hrs.
Hospital, Institution, or street address where death occurred:
Eugene Leland Memorial Hospital
How long in hospital or institution? 18 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4704 Rittenhouse St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Phelps, Mr. William Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Maggie Beatrice Phelps
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 24, 1888

8. AGE: Years	Months	Days	If less than one day
57			hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Plasterer
11. Industry or business: Plastering

FATHER
12. Name: John - Phelps
13. Birthplace: Virginia

MOTHER
14. Maiden name: ?
15. Birthplace: ?

18. Informant: Daughter Pearl Phelps
Address: Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/30/45 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetry
Location: Suitland md.
18. Funeral director: W W Chambers Co.
Address: Riverdale Md.

19. June 29 1945 (Date rec'd by registrar) James Leary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28, 1945 at 1:04 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to Hematorax	
Due to Crushed right chest	
Fracture left femur	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 6-27-45
Where did injury occur? Bennings D.C. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Pebble Island Cove
Means of injury: Pedestrian struck by auto Injured at work? No
Deputy medical Examiner

23. SIGNATURE: [signature] M. D. or other
Address: Forestville Md. Date signed 6-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

06292

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County Prince Georges
City or town (rural) Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 27 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 2 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 455 Mass. Ave. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME BYROM LEE PONDER

3.(b) Social Security Number 577-10-8520

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Elsie Talbot Ponder
6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) September 3, 1902

8. AGE: Years	Months	Days	If less than one day
42	9	12	...hrs. ...min.

9. Birthplace Cleveland, North Carolina (Town, county, and state)
10. Usual occupation Painter
11. Industry or business

FATHER
12. Name Julen C. Ponder
13. Birthplace Cleveland N. Carolina

MOTHER
14. Maiden name Ada Wright
15. Birthplace Cleveland, N. Carolina

16. Informant Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 16, 1945 (month) (day) (year)
Cemetery or crematory
Location to Washington D. C.
18. Funeral director W. W. Chamberlayne Co.
Address 1400 Chapin St. N.W.

19. June 15 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 19, 1945, to June 15, 1945
and that I last saw him alive on June 15 1945.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.
M. D. or other
Address Glenn Dale, Md. Date signed 6/15/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

06293

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: RURAL- Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 9 mo., 13 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 years, 9 mo., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2133½ Fourth St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: AMY V. PUMPHREY

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: George L. Pumphrey

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 18, 1897

8. AGE: Years	Months	Days	If less than one day
48	5	9	..... hrs. ..... min.

9. Birthplace: Prince Williams Co., Va.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: -

FATHER
12. Name: Joseph W. Gough
13. Birthplace: Prince Williams Co., Va.

MOTHER
14. Maiden name: Louise Rawlings
15. Birthplace: Prince Williams Co., Va.

16. Informant: decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 28, 1945 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: L. H. Hines Co.

Address: 2901- 14 st. N.W.

19. June 27 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1945 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 14, 1940 to June 27 1945 and that I last saw her alive on June 27 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	4 yr 10 mo
Due to: Tuberculous Enteritis	1½ yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincura MD
M. D. or other

Address: Glenn Dale, Md. Date signed: 6/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06294

CERTIFICATE OF DEATH

Reg. Dist. No. 243

I. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 5 mos., 5 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 5 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 Otis Place N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: Vincent F. Ready

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 4, 1908

8. AGE: Years	Months	Days	If less than one day
36	7	6	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Sheet Metal Worker

11. Industry or business:

FATHER
12. Name: Henry Ready
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Mary Cady
15. Birthplace: Ireland

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof June 11, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

19. Funeral director: W. W. Chambers & Co

Address: 3072 - M St. N.W.

19. June 10, 45 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1945 at 6 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1944, to June 10 1945 and that I last saw h.i.m. alive on June 10 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Bilateral pulmonary tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed: 6-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

C6295

Reg. Dist. No. 239

1. PLACE OF DEATH

County: Prince Georges Cnty

City or town: Laurel Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Laurel Rural Dist

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Gene Gray Reynolds

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 2 - 1944

8. AGE: Years | Months: 8 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Bethesda Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER — 12. Name: Lagnes Ford Reynolds

13. Birthplace: Texas

MOTHER — 14. Maiden name: Dorathy E Russell

15. Birthplace: Plemptont Md

16. Informant: Dorathy E Reynolds

Address: Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 14, 1945 (month) (day) (year)

Cemetery or crematory: Mt Carmell Md

Location: Montgomery Co Md

18. Funeral director: Rol W. Barbe

Address: Forestville Md

19. June 13 1945 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/7 1945 to 6/12 1945

and that I last saw h— alive on 6/12 1945

Immediate cause of death: Pneumonia Imediate

DURATION: 7

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

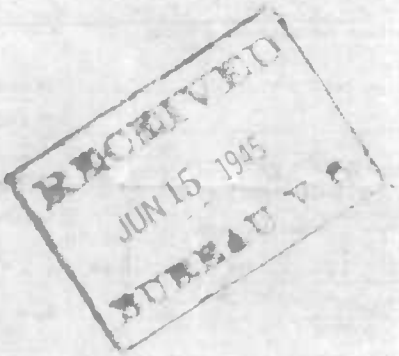
23. SIGNATURE: W B Kennard M. D. or other

Address: Laurel Md Date signed 6/12 45

VS A15

PLEASE WRITE PLAINLY, WITH INDELIBLE FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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JUN 15 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06296

CERTIFICATE OF DEATH

Reg. Dist. No. 243

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 25 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1316- 22 St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: JAMES E. ROBERTS

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 24, 1903

8. AGE: Years	Months	Days	If less than one day
42	2	25	hrs. min.

9. Birthplace: Portsmouth, Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: John Roberts
13. Birthplace: Danville, Virginia

MOTHER
14. Maiden name: Addie Leonard
15. Birthplace: Portsmouth, Virginia

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 6-18-45 (month) (day) (year)
Cemetery or crematory: Ft. Wash. D.C.
Location:
18. Funeral director: WETAVIS
Address: 1432 U St. N.W.

19. June 18, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18th 1945 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24th 1945 to June 18th 1945 and that I last saw h. alive on June 18th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 6/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Diat. No. 06297 243

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: RURAL- Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Washington County:
City or town: D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 535- N. Jersey Ave., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Clifton Shields

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife: –

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 30, 1941

8. AGE: Years	Months	Days	If less than one day
4	1	20	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: child

11. Industry or business:

FATHER
12. Name: Leroy Shields
13. Birthplace: Lynchburg, So. Carolina

MOTHER
14. Maiden name: Fannie Lowery
15. Birthplace: Lynchburg, So. Carolina

16. Informant: by mother
Address: 535- N. Jersey Ave., N.W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 20 1945 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.

18. Funeral director: Malvern & Soley Inc.
Address: 424 R St. N.W.

19. June 20 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 1945, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 1944 to June 20 1945
and that I last saw him alive on June 20 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane MD
M. D. or other
Address: Glenn Dale, Md. Date signed: 6-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (110-C)

CERTIFICATE OF DEATH

06298

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ~~Prince Georges~~

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 S. Caren Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ferdinand Bishop Siegmann Jr

3.(b) Social Security Number 219-22-1844

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1927

8. AGE: Years 17 | Months 6 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Neck Hand

11. Industry or business Transportation

FATHER 12. Name Ferdinand Bishop Siegmann

FATHER 13. Birthplace Baltimore Md

MOTHER 14. Maiden name Emma Kapp

MOTHER 15. Birthplace Baltimore Md

16. Informant Papers on body.

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 7, 1945 (month) (day) (year)

Cemetery or crematory Cole Funeral Home

Location 1200 Lombard St. Baltimore Md.

18. Funeral director E. Gasche sons

Address Hyattsville Md.

19. June 7 1945 James Seery Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1945 at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Crushed skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-7-45

Where did injury occur? Hyattsville (City or town) P.G. (County) Md (State)

Injured at home, farm, industry, public place (where?) Route #1

Means of injury Passenger in collision Injured at work? no

Deputy medical Examiner

23. SIGNATURE ..... M. D. or other

Address Forestville Md. Date signed 6-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-a)

06299

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Camp Springs Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Station Hospital, Andrews Field, Wash 20, DC
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No. - - -
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SLATER (No Given Name)

3.(b) Social Security Number: - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	- - -

6.(b) Name of husband or wife: - -
6.(c) If alive, give age: - years
7. Birth date of deceased (mo., day, yr.): 15 June 1945

8. AGE: Years	Months	Days	If less than one day
-	-	-	1 hrs. 22 min.

9. Birthplace: Station Hosp, Andrews Fld, Wash 20, DC
(Town, county, and state)
10. Usual occupation: - -
11. Industry or business: - -

FATHER
12. Name: Wilbur Wayne Slater
13. Birthplace: Erie, Pennsylvania

MOTHER
14. Maiden name: Helen Mae Partridge
15. Birthplace: Smyrna, New York

16. Informant: Mother: Mrs. Helen M. Slater
Address: La Plata, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof June 18 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill and buried June 19, 1945
Location: Arlington Cemetery

18. Funeral director: Chas S Zurhorst Inc
Address: 301 E. Capitol Washington DC

19. June 15 19 45 (Date rec'd by registrar) Sidney Brogman Capt A.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 June 19 45, at 2:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 June 19 45 to 15 June 19 45 and that I last saw her alive on 2:20 PM 15 June 19 45

Immediate cause of death	DURATION
Anoxia	
Due to Atelectasis, massive, involving all lobes of right and left lung,	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Atelectasis, massive
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Umbert E Anz
UMBERT E. ANZ, Captain, MC M. D. or other
Address: Andrews Fld, Washington, DC Date signed: 6/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M) (I) (T) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

CERTIFICATE OF DEATH

06304

Reg. Diat. No. 232

1. PLACE OF DEATH:
County Prince Georges
City or town Landover
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Landover
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Ann Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1945

8. AGE: Years | Months 1 | Days 3 | If less than one day hrs. min.

9. Birthplace Landover, Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name Dennis Smith
13. Birthplace Maryland

MOTHER 14. Maiden name Mabel Pender
15. Birthplace Maryland

16. Informant Mabel Smith
Address Landover, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27/45 (month) (day) (year)

Cemetery or crematory Woodmere

Location Pr Geo Co

18. Funeral director J. B. Johnson
Address Annapolis

19. June 26 19 45 R. Eugene Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 45, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia	
Due to Overlaying Mother	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner M. D. or other
Address Forestville Md Date signed 6-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

06300

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince George
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Rebecca Smith

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: John Walter Smith
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): not known

8. AGE: Years: 62 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: John Young
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice Richards
15. Birthplace: Maryland

16. Informant: John W Smith
Address: Upper Marlboro, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-23-45. (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: Upper Marlboro, Md.
18. Funeral director: Tippett Bros.
Address: Upper Marlboro, Md.

19. June 23 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 1945 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943, to June 1945
and that I last saw h.er alive on May 1945

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardio Vascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James D. Bond M. D. or other
Address: Forestville Md Date signed 6-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1572)

06301

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred:
How long in hospital or institution? Dead upon arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: College Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6814 - Dartmouth Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas O'Kelly Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rebecca Smith
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): June - 11 - 1915

8. AGE: Years: 30 | Months: | Days: | If less than one day: ...hrs. ...min.

9. Birthplace: Raleigh, N.C.
(Town, county, and state)

10. Usual occupation:

11. Industry or business: Navy Dept.

FATHER
12. Name: Smith, Wasidas
13. Birthplace: N.C.

MOTHER
14. Maiden name: Cown, Eleanor
15. Birthplace: N.C.

16. Informant: Mrs. Rebecca Smith
Address: College Park, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 6/23/45 (Month) (Day) (Year)
Cemetery or crematory: Oak Wood Cemetery
Location: Raleigh N.C.

18. Funeral director: W W Chambers Co
Address: Riverdale, Md.

19. 6/23 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 1945 at 1000 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9 1944 to June 22 1945
and that I last saw him alive on June 15 1945

Immediate cause of death	DURATION
Congenital Heart	
Pulmonary tuberculosis	
Fatigue	1 Years
Due to Interventricular Septum	
Defect and Patent Ductus Arteriosus	30 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: See Cause of Death
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W Brueggeman M.D.
M. D. or other
Address: Mt. Rainier Md. Date signed: 6-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

06302

Reg. Diat. No. 2 42

1. PLACE OF DEATH:
County: Prince George
City or town: Capital Hights (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Capital Hights (If outside city or town limits, write RURAL and give nearest town)
Street No.: 6101 Kingston Rd. (If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: ANNIE ELIZABETH STEELE

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wilsner N. Steele
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): August 29 1861

8. AGE: Years	Months	Days	If less than one day
83			____ hrs. ____ min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Peter Eagen
13. Birthplace: New York City
MOTHER 14. Maiden name: Sarah Kay
15. Birthplace: Washington DC
16. Informant: William E. Steele
Address: 6101 - Kingston Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 12 1945 (month) (day) (year)
Cemetery or crematory: Addison Road Cemetery
Location: Seat Pleasant Md.
18. Funeral director: J. William Lee & Son
Address: 300 - 4 St. N.E. D.C.
19. June 13 1945 (Date rec'd by registrar) Irene A. Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 19 45 at 2:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 45 to June 12 19 45 and that I last saw her alive on June 11 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to: General Arteriosclerosis	Unknown
Due to:	
Other conditions: Chronic myocarditis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Washington D.C. Date signed: June 12 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1840

06303

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
Warren Hospital
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County .....
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 220 S. Collins Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Adaline Stewart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	married

6.(b) Name of husband or wife Edgar Stewart
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) April 12, 1880

8. AGE: Years	Months	Days	If less than one day
65	1	25	..... hrs. ..... min.

9. Birthplace Penna
(Town, county, and state)
10. Usual occupation —
11. Industry or business —

FATHER
12. Name George Curley
13. Birthplace Md.

MOTHER
14. Maiden name Sabrina M. Phillips
15. Birthplace Pa.

16. Informant Mr Edgar Stewart
Address 220 S. Collins Ave.

17. Burial Date thereof 6.9.45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory London Park
Location 380, Frederick Rd
18. Funeral director Harry D Wirtz
Address 4101 Edmondson Ave.

19. June 9 19 45 (Date rec'd by registrar) A.W. Kedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 19 45, at 1 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 19 45, to June 7 19 45
and that I last saw h[illegible] alive on June 6 19 45

Immediate cause of death	DURATION
Bronchopneumonia	4 Days
Due to Cerebral Hemorrhage	7 Days
Due to Myocarditis	2 Yrs.
Due to Hypertension	
Other conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J M Warren M.D.
M. D. or Coroner
Address Laurel Date signed 6/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-6)

CERTIFICATE OF DEATH

06305

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5301 - Chesapeake Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Alice May Davis Tatum.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	married

6.(b) Name of husband or wife: Charles Hunter Tatum.
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1889

8. AGE:

Years	Months	Days	If less than one day
56	5	3	...hrs. ...min.

9. Birthplace: Georgia - Union County
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: George Davis
13. Birthplace: Georgia

MOTHER
14. Maiden name: Sarah Pruitt
15. Birthplace: Georgia

16. Informant: Mr. Charles H. Tatum
Address: 5301 - Chesapeake Rd Hyattsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md
18. Funeral director: L. Gascho sons
Address: Hyattsville Md

19. 6/25 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-23 1945, at 9 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1940, to 6-23 1945
and that I last saw her alive on 6-23 1945

Immediate cause of death	DURATION
Hemorrhage	
Esophageal - gastric	
Due to Cirrhosis of liver	1940
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. H. George M.D.
M. D. or other
Address: 3717 - 38th Ave Date signed: 6-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06306

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Pro Georges County
City or town: Mt. Rainier Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Geo Co
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3733 Wells ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: Mexican Uprising

3.(a) FULL NAME: William Edward Thomas

3.(b) Social Security Number: 220-03-9374

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Evelyn Thomas
6.(c) If alive, give age: 47 years
7. Birth date of deceased (mo., day, yr.): October 1, 1894

8. AGE: Years	Months	Days	If less than one day
50			....hrs. ....min.

9. Birthplace: Washington D. C. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Sup't-

FATHER
12. Name: William Edward Thomas
13. Birthplace: Washington D. C.

MOTHER
14. Maiden name: Kate Maxwell
15. Birthplace: Alexandria Virginia.

16. Informant: Mrs. Evelyn Thomas
Address: Mt. Rainier Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 13 1945 (month) (day) (year)
Cemetery or crematory: Glenwood
Location: Washington D.C.
18. Funeral director: F. G. Gatti's Sons
Address: Hyattsville Md

19. June 12, 1945 (Date rec'd by registrar) James Sevey, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11, 1945, at 245P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1943, to June 11, 1945
and that I last saw h... alive on June 11, 1945

Immediate cause of death	DURATION
Progressive Multiple Muscular Atrophy.	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work? ...

23. SIGNATURE: [illegible] M. D. or other
Address: Hyattsville Md Date signed: June 12/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06307

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Rogers Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, Institution, or street address where death occurred:
5010 - 54th Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Rogers Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5010 - 54th Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Warren Thompson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 25, 1873

8. AGE:

Years	Months	Days	If less than one day
71	9	15	..... hrs. ..... min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Circulation manager

11. Industry or business News Papers

FATHER
12. Name Asbury Upton Thompson
13. Birthplace D.C.

MOTHER
14. Maiden name Mary Jane Lock
15. Birthplace Pa

16. Informant Mrs Thomas M McPeak
Address Rogers Heights, Md

17. Burial Date thereof June 13, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Congressional
Location Washington D.C.

18. Funeral director W W Chambers Co
Address Riverdale Md

19. June 13 1945 James Berry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945 at 2:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardio Vascular renal Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Deputy medical Examiner James J. Boyd M. D. Coroner
Address Forestville Md Date signed 6-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

CERTIFICATE OF DEATH

T6308

Reg. Dist. No. 245

1. PLACE OF DEATH

County Pro Geo Co

City or town Hyattsville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? six weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va County Arlington Co

City or town 2600 N. 18th St

(If outside city or town limits, write RURAL and give nearest town)

Street No. Arlington Va

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME John Tracy

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 23, 1877

8. AGE:

Years	Months	Days	If less than one day
68	1	17	..... hrs. ..... min.

9. Birthplace Anamosa Iowa (Town, county, and state)

10. Usual occupation Radio Technician

11. Industry or business Private Industry

FATHER — 12. Name Michall Tracy

FATHER — 13. Birthplace Ireland

MOTHER — 14. Maiden name Charlotte Foley

MOTHER — 15. Birthplace Middletown Ohio

16. Informant Mary L. Tracy

Address 2600 N. 18 st Arlington Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14, 1945 (month) (day) (year)

Cemetery or crematory Holy Cross

Location Anamosa Iowa

18. Funeral director F. Gaeke sons

Address Hyattsville Md.

19. June 14 1945 James Severy

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 3:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-6-45 1945, to 10-10 1945 and that I last saw him alive on 10-9-45 1945

Immediate cause of death	DURATION
Carcinoma of stomach	12 Mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John P. Cum M.D. M. D. or other

Address Hyattsville Md Date signed 6-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

06309

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince Georges
City or town: Rural - Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 months
Hospital, Institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? 14 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5505 43rd Place
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Rose Summers Vincent

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Rufus H. Vincent
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 19, 1875

8. AGE:

Years	Months	Days	If less than one day
69	6	27	____ hrs. ____ min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Nathaniel Summers
13. Birthplace: D.C.

MOTHER
14. Maiden name: Martha Snow
15. Birthplace: D.C.

16. Informant: Mrs Muriel Dallas (daughter)
Address: 3 Ashford Ct, - Allston, Mass.
17. Removal (Burial, cremation, or removal? Which?) Date thereof June 16, 1945 (month) (day) (year)
Cemetery or crematory: Gude's Funeral Home
Location: Hyattsville Md
18. Funeral director: L. Gude & Sons
Address: Hyattsville Md
19. June 16 1945 M Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1945 at 5:29 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 7 1945, to June 16 1945
and that I last saw h[illegible] alive on June 16 1945

Immediate cause of death	DURATION
Chronic myocarditis	not known
Due to Chronic nephritis (nephrosclerosis)	"
Due to	
Other conditions Senile psychosis	"

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: L. J. Mc Neal M. D. or other
Address: Laurel, Md. Date signed 6/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 84a

CERTIFICATE OF DEATH

06310

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Hodges Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 4 mos
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1436 Tuckerman St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FRANCES WEINGARDEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 27, 1942

8. AGE: Years	Months	Days	If less than one day
2	6		hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Leo J. Weingarden
13. Birthplace: Detroit, Mich.

MOTHER
14. Maiden name: Helen Nevett
15. Birthplace: Manchester, England

16. Informant: Leo J. ~~Manchester~~ Weingarden
Address: 1436 Tuckerman St. N.W. Washington

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof June 27 45
(month) (day) (year)
Cemetery or crematory: Windsor, Ontario, Canada
Location: Canada

18. Funeral director: B. Danzansky & Son
Address: 3504-14th St. N.W.

19. 6/27 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1945, at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1944, to June 26 1945 and that I last saw her alive on June 15 1945

Immediate cause of death	DURATION
Bay Dacks disease	2 yrs 6 mos
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John J. Maloney, M.D.
M.D. or other
Address: Cheverly, Md. Date signed: 6-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

T 06311

Reg. Diat. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred:
616-618 Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2804-14th Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Williams Grimes Willis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife Edna M. Willis

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1895

8. AGE: Years	Months	Days	If less than one day
49	5	11	hrs. min.

9. Birthplace Strasburg, Va.
(Town, county, and state)

10. Usual occupation Train Master

11. Industry or business Washington Terminal

FATHER
12. Name Hancock Lee Willis
13. Birthplace Virginia

MOTHER
14. Maiden name Elizabeth Glover Ecklopp
15. Birthplace Virginia

16. Informant Neil J. Reynolds

Address 2804-14th St., Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8, 1945 (month) (day) (year)

Cemetery or crematory Orange, Virginia

Location

18. Funeral director The S. H. Hines Co.

Address 2901-14-st N.W. Washington, D.C.

19. June 6th 1945 (Date rec'd by registrar) Thos. S. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1945, at 7 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive Heart Failure	
Due to Cardiac vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner James J. Fogel M. D. or other

Address Forestville Md. Date signed 6-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

06312

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Boulevard Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, Institution, or street address where death occurred:
4804 - Byers street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Boulevard Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4804 Byers Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Catherine Eliza Wolfe

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Robert Wolfe
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Aug 27, 1875

8. AGE: Years	Months	Days	If less than one day
69	9	22	..... hrs. ..... min.

9. Birthplace: Brooklyn N.Y.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: John E Knable
13. Birthplace: New York.
MOTHER 14. Maiden name: Knable
15. Birthplace: New York
16. Informant: Robert Wolfe
Address: 4804 - Byers Street
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 6-16-45 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Bladensburg. Md
18. Funeral director: W. W. Chambers Co
Address: 517 11th St SE. DC
19. 6-14 1945 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14 1945 at 1:15 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardio vascular	
Due to: renal disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Deputy medical Examiner James J. Bond M. D. or other
Address: 7 Forestville Md Date signed: 6-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06313

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5705 42 Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Catherine M. Zimmerman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: John L Zimmerman
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 18, 1870

8. AGE: Years	Months	Days	If less than one day
74			..... hrs. ..... min.

9. Birthplace: N. Y. (Town, county, and state)
10. Usual occupation: at home
11. Industry or business
FATHER 12. Name: Marcel Bartholomew
13. Birthplace: France
MOTHER 14. Maiden name: Ellen —
15. Birthplace: Canada
16. Informant: John L. Zimmerman
Address: Hyattsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 29, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md
18. Funeral director: F Gaeta's Sons
Address: Hyattsville Md.
19. June 28, 1945 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1945, at H A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 27 1945
and that I last saw her alive on June 27 1945

Immediate cause of death	DURATION
Cardiac dilatation	immediate
Due to: Carcinoma of liver	3 mo
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

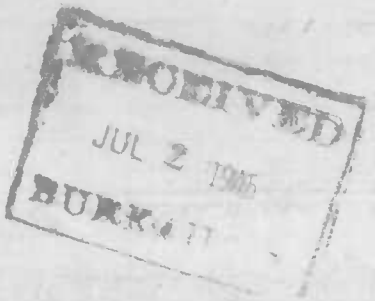
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Geo. D. Palmer M.D. M. D. or other
Address: Hyattsville Md Date signed: June 27 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15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